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No. 05-1424

IN THE
Supreme Court of the United States

METROPOLITAN LIFE INSURANCE COMPANY,

Petitioner,

v.

PEGGY HAWKINS-DEAN,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE* THE AMERICAN COUNCIL OF LIFE INSURERS IN SUPPORT OF PETITIONER AND BRIEF OF *AMICUS CURIAE*

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MOTION FOR LEAVE TO FILE BRIEF OF *AMICUS CURIAE*

The American Council of Life Insurers ("ACLI") hereby moves, pursuant to Rule 37.2 of the Supreme Court of the United States, for leave to file a brief as *amicus curiae* in support of Metropolitan Life Insurance Company's petition for writ of certiorari, No. 05-1424, to the United States Court of Appeals for the Ninth Circuit. Counsel for petitioner, Metropolitan Life Insurance Company, has consented to ACLI's filing an amicus brief in support of the petition. Counsel for respondent, Peggy Hawkins-Dean, was contacted on June 1, 2006 and declined to consent, thus necessitating this motion. A copy of ACLI's proposed amicus brief is attached.

ACLI is the largest life insurance trade association in the United States, representing the interests of 377 member legal reserve life insurers operating in the United States. These 377 member companies account for 91 percent of the industry's total assets, 90 percent of life insurance premiums in the United States among legal reserve life insurance companies, and 95 percent of annuity considerations. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The annuities issued include group annuities issued to employer-sponsored retirement plans. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

The ACLI is, accordingly, well-positioned to address the questions presented from the perspective of the insurance industry. ACLI seeks to file the proposed brief, and believes the brief can assist the Court, because the questions presented in the petition present significant issues for the industry as a whole and have practical ramifications far beyond the disposition of this particular case. The ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review

applicable under ERISA when an insurer, or any other administrator or fiduciary, is operating under an alleged conflict of interest significantly impact the manner and cost of operating employer-sponsored benefit plans and undermine the "uniformity of regulation" Congress sought to achieve in enacting ERISA.

The Ninth Circuit's decision to include a beneficiary's profit from the exercise of stock options as part of an employee's "basic monthly earnings" in calculating the benefits due under the plan also raises significant public policy concerns for the funding and underwriting of benefit plans, such as disability income plans and pension or retirement plans. As set forth in the brief, the Ninth's Circuit's decision is at odds with both the public policies underlying the benefit levels set forth in long-term disability plans and the manner in which policies funding such plans are priced and sold. These concerns should be before this Court for a proper evaluation of the questions presented.

Therefore, the ACLI respectfully requests that the Court grant leave to file the attached brief.

Respectfully submitted,

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INTEREST OF *AMICUS CURIAE*

As noted in the accompanying motion, the American Council of Life Insurers ("ACLI")[1] is the largest life insurance trade association in the United States. The life insurance policies issued by ACLI members include employer-sponsored group disability insurance policies and group life policies. The vast majority of the products sold by ACLI members in the group employee benefits market are subject to the requirements of the Employee Retirement Income Security Act of 1974 ("ERISA").

Of substantial concern to ACLI and its members is the ongoing conflict and confusion among the circuit courts of appeals regarding the standard of review applicable under ERISA to actions alleging denial of benefits when an insurer, or any other administrator or fiduciary, is operating under an alleged conflict of interest. This conflict is the subject of Questions 1 and 2 of the petition of Metropolitan Life Insurance Company ("petitioner" or "MetLife") for a writ of certiorari. ACLI is uniquely positioned to explain the practical ramifications of this conflict upon employer-sponsored benefit plans, and hence the need for the Court to resolve this conflict.

The Ninth Circuit's decision that a beneficiary's profit from the exercise of stock options must be included as "basic monthly earnings" in calculating the benefits due under the plan also is equally of concern to the ACLI and its members. The Ninth Circuit's decision raises significant public policy concerns for the funding and underwriting of benefit plans such as disability income plans and pension or retirement plans.

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1. Pursuant to Rule 37.6 of the Rules of the U.S. Supreme Court, the ACLI's counsel of record hereby certifies that this brief was authored in whole by Barnes & Thornburg LLP, and that no individual or entity other than the ACLI has contributed monetarily to the preparation of this brief.

SUMMARY OF ARGUMENT

ACLI respectfully urges the Court to grant the petition. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that a deferential standard of review is applicable to ERISA actions challenging denial of benefits where the benefit plan confers upon the administrator or fiduciary discretionary authority to determine eligibility for benefits or construe plan terms. In the 17 years since *Firestone* was decided, the lower federal courts have failed to develop a consistent, cohesive approach to applying that standard of review where an administrator or fiduciary of the benefit plan, whether it be an insured or a self-funded plan, is operating under an alleged conflict of interest. The result has been a widespread and deepening conflict among the circuit courts of appeals with respect to the degree of deference to be afforded in such circumstances. The various approaches adopted range from showing a high degree of deference to showing, as in the instant case, no deference at all and applying a *de novo* standard of review.

The standard of review in cases of conflicted administrators and fiduciaries concerns all insured plans and all plans that are both self-funded and self-administered, and hence a large proportion of ERISA actions brought in federal court alleging wrongful denial of benefits. The existing disarray among the circuits is particularly problematic because it severely undermines Congress' key objective in enacting ERISA – to establish a "uniform administrative scheme" for ERISA-covered benefit plans and a uniform body of federal common law for enforcement of such plans. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). Congress sought to establish this uniformity as part of its effort to encourage employers to establish benefit plans by eliminating the difficulties presented by and increased costs resulting from a patchwork of conflicting state and local laws. The disarray among the circuits also undercuts another congressional objective in enacting ERISA – providing an efficient, cost-effective enforcement scheme for the administration of benefit claim decisions.

As a practical matter, the lack of uniformity among the circuits on this issue is problematic because the multitude of approaches taken by the circuits leaves plans that wish to retain a traditional degree of discretion in making claims decisions without any clear guidance as to how the plan should be structured so that discretion can be preserved. Indeed, the only fail-safe position for doing so would appear to be self-funding the plan and hiring an independent third party administrator to render benefit determinations. Although this may be an option for large employers, medium and smaller employers are unlikely to have the necessary financial resources or infrastructure to self-fund a benefit plan.

ACLI also respectfully urges the Court to grant the petition with respect to Question 3 regarding the inclusion of profits from the exercise of stock options as "basic monthly earnings" in the calculation of plan benefits due to the significant public policy concerns the Ninth Circuit's decision raises. While the intended purpose of long term disability plans is to replace a portion of beneficiaries' normal earnings stream in the event of a qualifying disability, the Ninth Circuit's formulation of "earnings" can result in beneficiaries receiving benefits far in excess of their normal earnings stream. Herein, respondent's annual benefits (exclusive of offsets for certain other income or benefits) will exceed $91,000, even though her pre-disability annual income was only $28,850. It also raises significant issues in funding and underwriting such plans, given the vagaries in stock market valuation and beneficiaries' unpredictable actions and timing in exercising stock options.

REASONS FOR GRANTING THE PETITION

A. THE CIRCUIT COURTS OF APPEALS HAVE NOT RESOLVED THEIR CONFLICTING STANDARDS OF REVIEW IN THE CONTEXT OF CONFLICTED ADMINISTRATORS OR FIDUCIARIES.

In *Firestone*, this Court used analogy to the law of trusts to establish the standard of review applicable to actions for denial benefits brought pursuant to ERISA § 502(a)(1)(B), 29 U.S.C.

§ 1132(a)(1)(B). Recognizing that ERISA "abounds with the language and terminology of trust law," 489 U.S. at 110, this Court held that where the plan confers discretion upon a plan administrator or fiduciary, federal courts should review the claims decision only for an abuse of that discretion. *Id.* at 115.[2] In *Firestone*, the Third Circuit had held that a *de novo* standard of review should apply when the employer itself is the plan administrator because of "the lack of assurance of impartiality on the part of the employer." *Bruch v. Firestone Tire and Rubber Co.*, 828 F.2d 134, 137-145 (3d Cir. 1987). Because this Court rested its decision in *Firestone* upon trust law, and not a "concern for impartiality," the Court only briefly addressed in dictum the impact of a conflict of interest on a deferential standard of review. This Court noted that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an *abuse of discretion*.' " 489 U.S. at 115 (emphasis added) (quoting Restatement (Second) of Trusts § 187 cmt. d (1959)). This Court thus indicated that deference is still owed. In the 17 years since *Firestone* was decided, however, the Court has not provided any further guidance as to the manner in which deference is applied when an alleged conflict of interest exists.

With the dearth of guidance from this Court on this issue, the lower courts have developed conflicting and confusing standards. Federal courts and commentators alike have noted the conflicting approaches of the various circuit courts of appeals. The confusion is such that the circuits do not even agree on what constitutes a conflict, let alone on what standard of review should apply when a conflict is present and which party bears the burden of proof. Some circuits have held that the mere fact that an insurer both funds a plan and makes the

2. This is consistent with the general principle of trust law that where a trust confers discretionary authority upon a trustee, courts will not interfere with the trustee's exercise of that discretion absent indication that the trustee has abused that discretion. Restatement (Second) of Trusts § 187 cmt. d (1959).

benefits decisions under it constitutes an inherent conflict of interest. *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1326 (11th Cir. 2001). Others find that this is insufficient to establish an inherent conflict of interest. *Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 75 (1st Cir. 2005) (mere fact that plan administrator pays claims out of its own assets does not deprive the administrator of discretion granted by the plan); *Leipzig v. AIG Life Ins. Co.*, 362 F.3d 406, 409 (7th Cir. 2004) (most insurers are so well diversified that the decision in any one case has no perceptible effect on the bottom line; unless an insurer or administrator pays its staff more for denying claims than granting them, the people actually implementing benefit systems are impartial); *Perlman v. Swiss Bank Corp.*, 195 F.3d 975, 981 (7th Cir. 1999) (fact that plan insurer was also administrator did not amount to a conflict of interest because "[w]hen the administrator is a large corporation, the firm has a financial interest, but the award in any one case will have only a trivial effect on its operating results"). Still others find that this circumstance either may or may not amount to a conflict of interest. *Davolt v. Executive Comm. of O'Reilly Auto.*, 206 F.3d 806, 809 (8th Cir. 2000) (fact that the plan administrator is also the insurer may give rise to a conflict of interest, but assumption that such conflict exists is inappropriate).

As for the standard of review to be applied, the decisions of the various circuit courts of appeals defy easy classification. The Ninth Circuit holds that the mere existence of a conflict of interest is insufficient to alter the standard of review. In *Atwood v. Newmont Gold Co.*, 45 F.3d 1317, 1323 (9th Cir. 1995), the Ninth Circuit held that the deferential "arbitrary and capricious" or "abuse of discretion" standard of review applies unless the claimant presents "material, probative evidence, *beyond the mere fact of the apparent conflict*, tending to show the fiduciary's self-interest caused a breach of the administrator's fiduciary obligations to the beneficiary." *Id.* (emphasis added). If the claimant presents such evidence, however, the benefit

determination is presumptively void, although the administrator may rebut this presumption by producing evidence sufficient to establish that the same decision would have been made even absent the taint. If the plan fails to carry this burden, the decision is reviewed *de novo*. *Nord v. Black & Decker Disability Plan*, 296 F.3d 823, 829 (9th Cir. 2002), *rev'd on other grounds*, 538 U.S. 822 (2003).

The Second, Sixth and Seventh Circuits also essentially hold that the mere existence of a conflict of interest does not justify applying a less deferential standard of review unless there is evidence that the conflict in fact affected or tainted the benefit decision. *Sullivan v. LTV Aerospace & Defense Co.*, 82 F.3d 1251, 1255-56 (2d Cir. 1996) (claimant required to produce evidence that "the administrator was *in fact* influenced by" the alleged conflict of interest) (emphasis added);[3] *Peruzzi v. Summa Med. Plan*, 137 F.3d 431, 433 (6th Cir. 1998) (rejecting claimant's argument that a "less deferential" standard of review should apply where claimant failed to present evidence sufficient to establish that administrator was motivated by self-interest); *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998) (claimant must provide "specific evidence of actual bias" showing that there is "a significant conflict" before court will apply a less deferential standard of review).

The Eleventh Circuit essentially holds that claim determinations of a conflicted administrator or fiduciary automatically are subject to a less deferential standard of review, irrespective of whether there is any evidence that the conflict actually affected the benefit decision. *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1565 (11th Cir. 1990) (where claimant demonstrates a substantial conflict of interest on the part of the fiduciary responsible for benefits

3. If the claimant presents sufficient evidence that the conflict of interest affected the decision, the Second Circuit reviews the benefit determination *de novo*. *Sullivan*, 82 F.3d at 1255-56.

determinations, the burden shifts to the fiduciary to prove that its decision was not tainted by self-interest). Under the Eleventh Circuit's approach, the court first assesses whether the benefit determination is "wrong" from the perspective of a *de novo* review. *Levinson*, 245 F.3d at 1326. If so, the determination is considered arbitrary and capricious unless the conflicted administrator or fiduciary justifies the determination on the grounds of its benefit to the class of all plan participants and beneficiaries. *Id.*; *Brown*, 898 F.2d at 1566-67.

The Third, Fourth, Fifth and Tenth Circuits employ a "sliding scale" of deference, under which the reviewing court always applies the abuse of discretion standard, but the degree of deference varies inversely with the evidence establishing a conflict of interest. *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 391 (3d Cir. 2000) (adopting a sliding scale approach); *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 87 (4th Cir. 1993) (deference shown to the benefit decision "will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict"); *Vega v. National Life Ins. Servs. Inc.*, 188 F.3d 287, 297 (5th Cir. 1999) (*en banc*) ("[t]he greater the evidence of a conflict on the part of the administrator, the less deferential [the] abuse of discretion standard will be"); *Chambers v. Family Health Plan Corp.*, 100 F.3d 818, 826 (10th Cir. 1996) (adopting a sliding scale approach).

As the Tenth Circuit recently observed, the Circuits that have adopted the sliding scale approach provide no guidance as to "how much less" deference the reviewing court should afford the conflicted administrator. *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004), *cert. denied*, 125 S.Ct. 1972 (2005). Under the Tenth Circuit's version of the sliding scale approach, the court shifts the burden of proof to the conflicted administrator or fiduciary, who must establish that its decision was reasonable under the traditional arbitrary and capricious standard. Where a sufficiently severe conflict

of interest exists, the court shows less deference to the administrator. *Id.* at 1183.

Although the Eighth Circuit previously indicated that it subscribed to the Eleventh Circuit's approach in *Brown*, *see Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997) (holding that the "perpetual conflict" which exists when an insurer administers benefits from its own plan warrants a *de novo* standard of review), it now appears to have settled upon the sliding scale approach, albeit a modified version. *Phillips-Foster v. UNUM Life Ins. Co. of Am.*, 302 F.3d 785, 795 (8th Cir. 2002) (following the sliding scale approach); *Woo v. Deluxe Corp.*, 144 F.3d 1157, 1161-62 (8th Cir. 1998) (explicitly adopting the sliding scale approach). Under the Eighth Circuit's variation, a sliding scale of deference is applied only if the claimant presents "material probative evidence demonstrating that (1) a palpable conflict of interest or a serious procedural irregularity existed, which (2) caused a serious breach of the plan administrator's fiduciary duty to [the claimant]." *Woo*, 144 F.3d at 1160, *quoted in Barnhart v. UNUM Life Ins. Co. of Am.*, 179 F.3d 583, 587-88 (8th Cir. 1999).

The First Circuit applies another test, assessing the "reasonableness" of the benefit determination in light of the context in which the decision was made. *Doe v. Travelers Ins. Co.*, 167 F.3d 53, 57 (1st Cir. 1999).

The Ninth Circuit's decision below exemplifies further the confusion surrounding the applicable standard of review. In a very brief, unpublished opinion, the Ninth Circuit held that, notwithstanding the plan's grant of discretion, a *de novo* standard of review should apply based solely on the fact that in earlier proceedings, MetLife initially had determined that respondent was ineligible for benefits, but subsequently reversed itself. MetLife's decision to resolve its prior dispute with respondent by awarding benefits is not probative of whether a purported "conflict of interest" influenced its separate and distinct determination in calculating the benefits owing. The Ninth

Circuit's decision creates a perverse incentive for plans to never alter their determinations, despite ERISA's contrary purpose of mandating that, upon request of the beneficiary, plans fully and fairly review all benefit decisions without deference to the initial determination, altering the determination if warranted by the review.

B. THE CONFLICT AMONG THE CIRCUITS UNDERMINES BASIC ERISA POLICIES AND ADVERSELY AFFECTS EMPLOYEE BENEFIT PLANS.

1. The Standard of Review Issue Affects A Large Proportion of ERISA Litigation

It is important for the efficient operation of employer-sponsored benefit plans covered by ERISA that this Court resolve the conflict among the circuits on the standard of review. Given the large number of plans that are either insured or both self-funded and self-administered, the question of the standard of review applicable to benefit determinations rendered by allegedly conflicted administrators and/or fiduciaries frequently arises. As this Court noted in *Firestone*, the decision regarding the standard of review can be determinative of the outcome of the action. 489 U.S. at 115.

It also is important that the Court resolve this conflict because of the broad scope of ERISA actions it affects. ERISA applies to a variety of employer-sponsored benefit plans, the most common of which are health benefit plans, disability income insurance plans, life insurance plans and pension plans. Disputes over the standard of review can affect virtually every aspect of a wide range of benefit decisions. A few examples are:

1) in the context of a health benefits plan, whether a particular medical treatment is medically necessary,[4] experimental or otherwise not

4. *Doe v. Travelers Ins. Co.*, 167 F.3d at 58-59.

covered by the plan;[5] and whether a particular condition qualifies as a preexisting condition;[6]

2) in the context of disability income insurance plans, whether the claimant is disabled as defined by the plan,[7] and whether any plan limitations on benefits are applicable to the claims (*e.g.*, limitations on mental or psychiatric illnesses);[8]

3) in the context of life insurance plans, whether the insured's death was accidental;[9] and

4) in the context of pension plans, years of service credit and the level of pension benefits.[10]

The issue even arises in the context of the plan's determination whether a particular individual is an employee or beneficiary covered by the plan. *See Vega*, 188 F.3d 287.

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5. *Peruzzi*, 137 F.3d at 433-35.

6. *Davolt*, 206 F.3d at 809; *Chambers*, 100 F.3d at 818.

7. *Alford v. DCH Foundation Group Long Term Disability Plan*, 311 F.3d 955, 960 (9th Cir. 2002); *Levinson*, 245 F.3d at 1325-27; *Pinto*, 214 F.3d at 379.

8. *Cochran v. Trans-General Life Ins. Co.*, 12 Fed.Appx. 277, 2001 WL 392050 (6th Cir. Apr. 13, 2001); *Lang v. Long Term Disability Plan of Sponsor Applied Remote Tech. Inc.*, 125 F.3d 794, 799 (9th Cir. 1997).

9. *Mers*, 144 F.3d at 1024; *Hung v. Guardian Life Ins. Co. of Am.*, 28 Fed.Appx. 268, 2002 WL 104234 (4th Cir. Jan. 28, 2002).

10. *Johannsen v. District No. 1— Pacific Coast Dist, MEBA Pension Plan*, 292 F.3d 159 (4th Cir. 2002).

2. The Conflict Undermines the National Uniform Regulation Intended by ERISA, and Consequently Increases the Cost to Employers of Providing Benefit Plans.

Conflicting interpretations of federal law are disfavored generally and they are particularly problematic in the ERISA context. The ongoing conflict and confusion with respect to the standard of review applicable to benefit decisions of conflicted administrators and fiduciaries undermines the public policies underlying ERISA. In enacting ERISA, Congress was mindful not only of the need to establish certain minimum standards to protect the rights of employees, but also of the fact that benefit plans are voluntary on the part of employers. H.R. Rep. No. 93-533, at 9 (1973), *reprinted in* 1974 U.S.C.C.A.N. 4639, 4647. One of ERISA's bedrock purposes therefore is to encourage the formation of employee benefit plans. 29 U.S.C. § 1001b(c)(2). Congress accordingly sought to minimize disincentives to the establishment of such plans and to facilitate their establishment at a reasonable cost.

The basic thrust of ERISA is to avoid multiplicity of regulation in order to permit uniform national administration of employee benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1995). For over 30 years, ERISA's uniform regulation of employee benefit plans has fostered and protected the development of a system that extends crucial employee benefits to a vast swath of the nation's working population. ERISA has encouraged employers to take on the challenge of sponsoring benefit plans to provide employees and other beneficiaries with substantial financial protection from the high cost of health care, from the financial risk of a disabling illness or injury, and for financial security in retirement. A key component of ERISA's success in expanding and enhancing employee benefits is the protection it affords plan sponsors, which frequently have employees and operations in many states, from the burdens of

having to comply with multiple regulatory regimes. As this Court has noted, conflicting requirements make benefit administration more difficult and inefficient. When inefficiencies or difficulties are introduced into the benefit administration system, employers may decide to reduce the level of benefits offered, or to cease offering the benefits entirely. *Fort Halifax Packing Co.*, 482 U.S. at 11.

The disruption to a uniform system of administration is no less problematic when the lack of uniformity stems from conflicting interpretations of federal law, than when it results from conflicting state laws and regulatory requirements. In either context, unless the most stringent of the conflicting requirements is adhered to, claims procedures must be tailored to the particular jurisdiction in which the claim arises. Both situations increase the cost of providing benefits for all participants.

Moreover, due to the conflict on this issue, there is no clear guidance as to how claims processing should be structured so that plans can successfully retain a traditional degree of discretion in making claims decisions. Indeed, approaches adopted by certain circuits in practice essentially result in a *de novo* standard of review.

3. The Circuit Conflict Undermines ERISA's Civil Enforcement Scheme, Increasing Litigation and Consequently Further Increasing the Cost to Employers of Providing Benefit Plans.

Another essential part of ERISA's statutory scheme is its "carefully integrated" civil enforcement scheme, which this Court has described as "one of the essential tools for accomplishing the stated purposes of ERISA." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990), *citing Pilot Life Ins. Co. v Dedeaux*, 481 U.S. 41, 52, 54 (1987). The primary goal of this scheme is "to provide a method for workers and beneficiaries to resolve disputes over benefits inexpensively and

expeditiously." *Taft v. Equitable Life Assur. Soc.*, 9 F.3d 1469, 1472 (9th Cir. 1993). Under an abuse of discretion standard of review, the admissible evidence is limited to the administrative record, which consists of the insurance policy or plan document and claim file. Costly discovery of additional evidence (e.g., document requests, depositions, expert witness fees and reports) is either prohibited, unnecessary or severely limited. Because admissible evidence is typically limited to documents contained in the administrative record, ERISA lawsuits can be resolved promptly through dispositive motions by allowing the reviewing court to focus on the issue of whether the claim determination was reasonable and supported by substantial evidence. ERISA litigation typically is resolved quickly and without the opportunity for attorneys from both sides to generate enormous amounts of discovery and to engage in costly and unnecessary activity. This relatively inexpensive method of litigation inures to the benefit of all plan participants by helping to maintain the costs for providing employee benefits at a reasonable level.

The current conflict and confusion among the circuit courts of appeals regarding the standard of review applicable to decisions of conflicted administrators and fiduciaries undermine this purpose by rendering ERISA's enforcement mechanism more costly in terms of both time and financial resources. Because of the ongoing uncertainty on this issue, the applicable standard of review for a conflicted decision maker is frequently litigated in ERISA actions, causing the parties to spend additional time and money in litigation. The uncertainty also generates additional litigation because the parties are less able to assess how the benefit determination will be viewed by reviewing courts.

4. The Conflict Negatively Impacts Benefit Plans and Employers in Additional Ways.

The conflict and confusion surrounding the applicable standard of review has additional significant negative ramifications for benefit plans, whether insured or self-funded.

The conflict creates an incentive for employers who desire a traditional degree of deference in their benefit plans to leave the insurance market or simply not offer the benefit plan. There essentially are three basic options in structuring a benefit plan: 1) insure the plan; 2) self-fund and self-administer the plan; or 3) self-fund the plan but hire an independent third party administrator to administer benefit claims. Under the current patchwork of federal decisions, the only fail-safe means of preserving a traditional degree of deference appears to be the third option — structuring the plan so that separate entities fund and administer the plan. Although self-funding and retaining a third party administrator may be an option for large employers, medium-sized and smaller employers rarely have the necessary financial resources, infrastructure or desire to self-fund a benefit plan. Medium and smaller employers with no practical alternative to funding a benefit plan through the purchase of insurance may end up bearing not only the increased cost resulting from an uncertain standard of review, but also increased costs stemming from a flight of larger employers from the insurance market. As a result, medium and smaller employers in particular may choose either to offer a reduced level of benefits, or not to offer benefit plans at all.[11]

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11. In fact, only about one fourth of workers employed by small employers have disability benefits. *See National Compensation Survey: Employee Benefits in Private Industry in the United States*, March 2005, U.S. Department of Labor, Bureau of Labor Statistics, August 2005, *available at* http://www.bls.gov/ncs/ebs/sp/ebsm0003.pdf. At private establishments with less than 100 workers, 28 percent of workers are covered by a short-term disability plan and 19 percent are covered by a long-term disability plan. *Id.* at 8 (Table 4). In a 2002 ACLI survey, small employers who did not offer disability coverage to their workers cited cost as the primary reason for not offering coverage. *See Disability Income Insurance: Penetrating the Small-Employer Market*, ACLI, 2002, *available at* http://www.acli.org/ACLI/About+ACLI+nonmember/Industry+Facts/DI+Insurance+Small-Employer+Market+Survey.htm. Sixty-seven percent of small employers without disability coverage classify "coverage is too expensive" as a major reason they do not offer it; an additional 10 percent report this is a minor reason. *Id.* at 8.

C. A TRADITIONAL DEFERENTIAL STANDARD OF REVIEW SHOULD APPLY.

ACLI respectfully submits that benefit determinations rendered by administrators or fiduciaries who are afforded discretion by the terms of the benefit plan but are operating under an alleged conflict of interest should be reviewed under a traditional deferential standard of review in accordance with *Firestone*. Under *Firestone*, a potential conflict of interest is but one of several factors that must be considered in determining whether an abuse of discretion has occurred. It does not, however, modify the standard of review or in any way negate the plan's grant of discretion.

The circuit courts of appeals that have adopted the "presumptively void" and the "sliding scale" approaches essentially determine the standard of review based on who the administrator or fiduciary is. As this Court determined in *Firestone*, the appropriate standard of review under ERISA derives from trust law, and not a concern for impartiality. 489 U.S. at 115. Indeed, ERISA itself permits entities with a conflict of interest to nevertheless act as administrators or fiduciaries. 29 U.S.C. § 1108(c)(3). When the benefit plan grants such entities discretion to make benefit determinations, federal courts should not negate the grant of discretion by altering the standard of review based merely on the potential for a conflict of interest. Moreover, the sliding scale approach creates the danger that that the outcome will be strongly influenced by the sympathetic facts of a particular case.

These approaches also undervalue the role that deference plays in the formation of benefit plans. Upholding a plan's grant of discretionary authority through application of a deferential standard of review provides plan sponsors with a degree of control over the benefit plan and promotes its affordability. As this Court has noted, ERISA does not mandate what, if any,

benefits an employer must provide and employers have large leeway to design their plans. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 833 (2003). Plans therefore have a legitimate interest in retaining discretion to interpret the terms of the plan and to render benefit decisions. Given the enormously wide range of issues that can arise in rendering benefit decisions under any plan, it is not possible to predict every type of issue and claim that may arise. Moreover, all plans have some terms that are arguably ambiguous as applied to peculiar facts. Discretion and a deferential standard of review enable the plan to resolve such issues in a manner that best protects the interests of all participants in the plan.

Application of a deferential standard of review also provides adequate protection for the interests of the claimants under benefit plans. As Judge Easterbrook recently wrote for the Seventh Circuit, an employer

> has no reason to deceive its employees about the quality of fringe benefits on offer; that would just besmirch its reputation and make it harder to hire good people in competition with other [employers]. One might as well say that because a health maintenance organization has an incentive to skimp on care (for it does not collect extra fees for additional medical services), the judiciary must intervene to force HMOs to offer more or better care than they have promised by contract. Yet the Supreme Court held in *Pegram v. Herdrich*, 530 U.S. 211, 147 L. Ed. 2d 164, 120 S. Ct. 2143 (2000), that HMOs' well-known incentive to shave the costs of care does not justify "correction" under the banner of ERISA. The choice between fee-for-service and HMO-style incentives, neither of them perfect, is left to employers who must compete for good

> workers using a combination of salary and fringe benefits.

Leipzig, 362 F.3d at 408-409. Similarly with respect to benefit claims decisions by insurers under insured plans, the Seventh Circuit previously explained that:

> [I]t is a poor business decision [for an insurer] to resist paying meritorious claims for benefits. Companies . . . that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans. . . . [These employers] want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers.

Mers, 144 F.3d at 1021.

Industry statistics regarding claims denials also provide strong evidence to dispute the myth that insurers are motivated to deny valid claims, and buttress the foregoing analysis of the Seventh Circuit. A 2002 claims survey conducted by the Health Insurers Association of America ("HIAA") of its members' claims experience revealed that on average 14% of health benefit claims were denied. Significantly, 48% of all claims denials were due to the submission of a duplicate claim, 22% were denied because the policy had lapsed and 20% were denied because the individual was no longer covered under the policy. HIAA, "Results from an HIAA Survey on Claims Payment Processes," at 10 (March 2003), *available at* http://www.ahipresearch.org/PDFs/21_ClaimsPaymentProcessesSurvey

Chartbook.pdf. The remaining 10% of denied claims represents only 1.4% of the total claims reported.[12]

As these statistics amply demonstrate, the overwhelming majority of benefit claims are paid by insurers. In sum, the assumption implicitly underlying the "presumptively void" and "sliding scale" approaches – that self-interested administrators and fiduciaries are motivated to deny valid claims – is not correct.

D. THE NINTH CIRCUIT'S INCLUSION OF STOCK OPTION PROFITS IN "BASIC MONTHLY EARNINGS" FOR PURPOSES OF CALCULATING PLAN BENEFITS RAISES SIGNIFICANT PUBLIC POLICY CONCERNS.

The Ninth Circuit's decision raises significant public policy concerns for the funding and underwriting of benefit plans, especially for disability income plans. The intended purpose of long term disability plans is to replace a portion of beneficiaries' normal earnings stream in the event of a qualifying disability (approximately 60% less offsets for certain other income to which the beneficiary may be entitled, such as Social Security Disability Income benefits). This benefit level makes disability plans more affordable for employers and also preserves motivation for employees who suffer a disabling condition to pursue rehabilitation and/or retraining for other suitable employment. The Ninth Circuit's decision can result in beneficiaries receiving windfall benefits far in excess of their normal earnings stream, particularly where beneficiaries refrain from exercising stock options or selling the stock until shortly before the qualifying event, *i.e.*, the onset of a disabling condition. In the case at hand, the inclusion of profits from respondent's exercise of accumulated stock options resulted in her base annual income for calculating benefits increasing to $151,855 from $28,850. (Pet. at 5.) This more than five-fold

12. The ACLI is not aware of any studies that compile statistics on the denial of long term disability claims.

increase results in respondent's annual disability benefits dwarfing her normal, pre-disability income.[13] As a result, the public policies underlying the plan's benefit level are severely undermined.

The Ninth Circuit's decision also raises significant issues in funding and underwriting such plans, given the vagaries in stock market valuation and beneficiaries' unpredictable actions and timing in exercising stock options or selling the stock. Premiums for insured disability plans are determined based on the number of covered employees, the payroll earnings reported by the employer for the covered employees, and actuarial data regarding the likely incidence of qualifying disability for the group. Because income cannot be realized from stock options until they are exercised by the employee, the earnings reported by employers for purposes of calculating policy premiums typically do not include the potential income that may be realized upon the exercise of those options or sale of stock. Indeed, the inclusion of such potential income in the employer's reporting of employee earnings raises numerous practical issues given the multitude of uncertainties surrounding the realization of any income from stock options. Chief among these uncertainties are the vagaries of the stock market and the fluctuating value of the underlying stock. Under certain circumstances, stock options may not even be exercised if they will result in little or no realized income.

The fact that the employee, and not the employer, makes the ultimate decision as to whether and when to exercise the stock options also is a significant complication. The employer merely sets the price at which the employee can purchase the number of shares covered by the stock option. The income, if any, ultimately realized through exercise of the stock options depends upon the employee's timing in exercising the options

13. Per respondent's calculations, the monthly benefit due her under the plan is $7,592.75, exclusive of offsets for other income. (Respondent's App. Br. at 4.) Her annual benefit therefore would be $91,113.

and decisions regarding whether to hold or sell the stock.[14] As a result, the premiums charged for the policies funding long term disability plans typically do not encompass the windfall income that can result from the exercise of stock options. Including such windfall income in calculating plan benefits imposes liability for which no corresponding premium was collected.

CONCLUSION

ACLI respectfully requests that the Court grant Metropolitan Life Insurance Company's petition for a writ of certiorari.

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14. The fact that the employee controls the exercise of the stock option also can lead to unintended wide disparities among similarly-situated employees as to the amount of disability benefits ultimately received. The additional annualized income realized from the exercise of stock options may be significantly less for employees who frequently exercise vested stock options in order to average the associated risk, as opposed to those employees who accumulate options and exercise them all at once. Although the employer has conveyed the right to purchase the stock at a set rate, employees use and exercise those rights in different ways. For this reason, stock options are more analogous to fringe benefits, than to salary or wages.